PUBLIC HEALTH, WELFARE & SAFETY
Exhibit No. 2
Date 3-19-07
Bill No. HB 687

Amendments to House Bill No. 687
HB0687.03

Requested by Blue Cross and Blue Shield of Montana
Prepared by Greg Gould
Last printed 03/19/2007 1:47 PM

1. Title, line 5
Following: "7;"
Strike: "AND"

2. Title, line 6
Following: "MCA"
Insert: "; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY DATE"

3. Page 10, line 23
Following line 22
Insert: "NEW SECTION. **Section 5. Effective date.** [This act] is effective January 1, 2008."

4. Page 10, line 23
Following New Section 5
Insert: "NEW SECTION. **Section 6. Applicability date.** [This act] is applies to policies, certificates, evidences of coverage and plans issued or renewed on or after January 1, 2008."

-end-

Amendments to House Bill No. 687
HB0687.03

Requested by Blue Cross and Blue Shield of Montana
Prepared by Greg Gould
Last printed 03/19/2007 1:48 PM

1. Title, line 4
Following: "INSURANCE"
Insert: "AND HEALTH PLAN"

2. Title, line 5
Following: "SECTIONS"
Insert: "2-18-704,"
Following: "33-3-1014,"
Strike: "AND"

3. Title, line 6
Following: "33-31-301,"
Insert: "AND 33-35-306,"

4. Page 1, line 10
Before Section 1
Insert: **Section 1.** Section 2-18-704, MCA, is amended to read:

"2-18-704. Mandatory provisions. (1) An insurance contract or plan issued under this part must contain provisions that permit:

(a) the member of a group who retires from active service under the appropriate retirement provisions of a defined benefit plan provided by law or, in the case of the defined contribution plan provided in Title 19, chapter 3, part 21, a member with at least 5 years of service and who is at least age 50 while in covered employment to remain a member of the group until the member becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, as amended, unless the member is a participant in another group plan with substantially the same or greater benefits at an equivalent cost or unless the member is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost;

(b) the surviving spouse of a member to remain a member of the group as long as the spouse is eligible for retirement benefits accrued by the deceased member as provided by law unless the spouse is eligible for medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible for equivalent insurance coverage as provided in subsection (1)(a);

(c) the surviving children of a member to remain members of the group as long as they are eligible for retirement benefits accrued by the deceased member as provided by law unless they have equivalent coverage as provided in subsection (1)(a) or are eligible for insurance coverage by virtue of the employment of a surviving parent or legal guardian.

(2) An insurance contract or plan issued under this part must contain the provisions of subsection (1) for remaining a member of the group and also must permit:

(a) the spouse of a retired member the same rights as a surviving spouse under subsection (1)(b);

(b) the spouse of a retiring member to convert a group policy as provided in 33-22-508; and

(c) continued membership in the group by anyone eligible under the provisions of this section, notwithstanding the person's eligibility for medicare under the federal Health Insurance for the Aged Act.

(3) (a) A state insurance contract or plan must contain provisions that permit a legislator to remain a member of the state's group plan until the legislator becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, as amended, if the legislator:

(i) terminates service in the legislature and is a vested member of a state retirement system provided by law; and

(ii) notifies the department of administration in writing within 90 days of the end of the legislator's legislative term.

(b) A former legislator may not remain a member of the group plan under the provisions of subsection (3)(a) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost; or

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.

(c) A legislator who remains a member of the group under the provisions of subsection (3)(a) and subsequently terminates membership may not rejoin the group plan unless the person again serves as a legislator.

(4) (a) A state insurance contract or plan must contain provisions that permit continued membership in the state's group plan by a member of the judges' retirement system who leaves judicial office but continues to be an inactive vested member of the judges' retirement system as provided by 19-5-301. The judge shall notify the department of administration in writing within 90 days of the end of the judge's judicial service of the judge's choice to continue membership in the group plan.

(b) A former judge may not remain a member of the group plan under the provisions of this subsection (4) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost;

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost; or

(iii) becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, as amended.

(c) A judge who remains a member of the group under the provisions of this subsection (4) and subsequently terminates membership may not rejoin the group plan unless the person again serves in a position covered by the state's group plan.

(5) A person electing to remain a member of the group under subsection (1), (2), (3), or (4) shall pay the full premium for coverage and for that of the person's covered dependents.

(6) An insurance contract or plan issued under this part that provides for the dispensing of prescription drugs by an out-of-state mail service pharmacy, as defined in 37-7-702:

(a) must permit any member of a group to obtain prescription drugs from a pharmacy located in Montana that is willing to match the price charged to the group or plan and to meet all terms and conditions, including the same professional requirements that are met by the mail service pharmacy for a drug, without financial penalty to the member; and

(b) may only be with an out-of-state mail service pharmacy that is registered with the board under Title 37, chapter 7, part 7, and that is registered in this state as a foreign corporation.

(7) An insurance contract or plan issued under this part must include coverage for treatment of inborn errors of metabolism, as provided for in 33-22-131.

(8) An insurance contract or plan issued under this part must include substantially equivalent or greater coverage for outpatient self-management training and education for the treatment of diabetes and certain diabetic equipment and supplies as provided in 33-22-129.

(9)(a) An insurance contract or plan issued under this part that provides coverage for an individual in a member's family must provide coverage for well-child care for children from the moment of birth through 7 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the contract or plan.

(b) Coverage for well-child care under subsection (a) must include:

(i) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(ii) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(c) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this subsection (9).

(d) For purposes of this section:

(i) "well-child care" means the services described in subsection (b) and delivered by a physician or a health care professional supervised by a physician; and

(ii) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics."

Renumber subsequent sections

5. Page 10, line 23
Following Section 4
Insert: **Section 6.** Section 33-35-306, MCA, is amended to read:

"33-35-306. Application of insurance code to arrangements. (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions:

(a) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(b) Title 33, chapter 1, part 7;

(c) 33-3-308;

(d) Title 33, chapter 18, except 33-18-242;

(e) Title 33, chapter 19;

(f) 33-22-107, 33-22-131, 33-22-134, and 33-22-135; and

(g) 33-22-512, 33-22-525 and 33-22-526.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

-end-

Current State Mandates—2006

- Chemical Dependency
- Continuation of Coverage for Disabled Dependents
- Convalescent Care
- Creditable Coverage
- Dentist Services
  —Common to both medicine and dentistry
- Diabetes Education, Equipment and Supplies
- Mammograms
- Mental Health
- Minimum Stay After Childbirth
- Naturopathic Physician
- Newborns: First 31 days
- Nurse Specialists
- Physical Therapists
- Physician Assistants
- PKU-Metabolic Disorders
- Post-Mastectomy Care
- Prescription Contraceptives
- Pre-existing Condition
  —Look-back period of 6 months
- Self-Referral for OB/GYN
- Severe Mental Illness
  —Cover as any other illness
- Well-Child Care and Immunizations

Consumer Choice,
Rather Than Mandate
Get Involved!

Current Federal Mandates—2006

- Creditable Coverage
  —For groups over 50
- Mental Health Parity
- Post-Mastectomy Care
- Pre-existing Look-Back Period

Monthly Cost PMPM*

Total $21.22

Other Hot Topics in Healthcare

Blue Cross and Blue Shield of Montana continues to monitor these and many other issues at both the State and Federal levels:

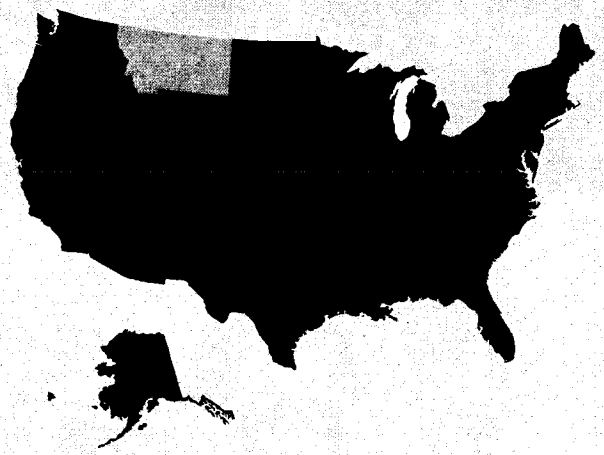
- Rapidly Rising Health Care Costs
- Uninsured Montanans' Tax Credits
- Montana Comprehensive Health Association
- Privacy of Health Information
- Prescription Drugs and Costs
- Medicaid and Medicare Reimbursement
- Children's Health Insurance Program, Caring Program for Children

Potential New State Mandates—2007

	Monthly PMPM*
Acupuncture Service	$ .18
Chemical Dependency Parity	2.15
Chiropractic Supplies	1.30
Mental Health Parity	7.51
Morbid Obesity	
TMJ (temporomandibular joint disorder)	.41
Hearing Aid [SB151] (per ear)	2.51
(**Pediatric Audiology [SB101])	
TOTAL:	**$14.06**

Mandates Affect Rates

Current State and Federal mandates cost Blue Cross and Blue Shield of Montana's members millions annually. Proposed mandates would add to that cost.



*per covered Montanan per month

**scaled back bill if passed on its own could be PMPM $1.25

Presented by Mark Buzynski BCBSMT
Senate Public Health 3/19/09